STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105616	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrington Place of St Pete	10501 Roosevelt Blvd N Saint Petersburg, FL 33716

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46498 Based on observations, interviews, and review of facility policy, the facility failed to ensure a safe and homelike environment was provided in 13 resident rooms (#201, #203, #118, #114, #108, #107, #110, #112, #259, #253, #138, #137, and #146) of 74 resident rooms in the facility. Findings included: 1. During an observation made on 3/24/2025 at 9:14 a.m., room [ROOM NUMBER] was observed with a hole in the wall behind the room door. During an observation made on 3/24/2025 at 9:30 a.m., room [ROOM NUMBER] was observed with a loose toilet seat attached to the resident's bathroom toilet. 20536 2. During facility tours on 3/24/2025 at 9:40 a.m., 3/25/2025 at 8:10 a.m., and on 3/26/2025 at 7:45 a.m. and 9:00 a.m., the following was observed: a. Resident room [ROOM NUMBER]'s bathroom was observed with two plastic straight edge razors on the sink counter. Neither were labeled as to who they belonged to. There were two residents residing in the room during all days observed. b. In resident room [ROOM NUMBER], in the right corner of the room near the window, an approximately one foot section of the ceiling was observed peeling and appeared water logged from a water leak. The area of the ceiling was peeled and falling to the floor. The wall area behind the head board of the window bed and to the side of the head of the bed appeared unpainted. c. In resident room [ROOM NUMBER], the wall behind the window bed was scratched/gouged and in need of repair and paint. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105616	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. In resident room [ROOM NUMBER], the walls behind the window bed were gouged and in need of repair and paint. The ceiling near the right side of the window was observed with heavy water damage and ceiling paint peeling up. e. In resident room [ROOM NUMBER], the ceiling near the window appeared with damaged and peeling due to what appeared to be water damage. f. In resident room [ROOM NUMBER], the ceiling near the window appeared with damaged and peeling due to what appeared to be water damage. 51097 During an observation on 3/24/2025 at 9:30 a.m. of room [ROOM NUMBER], a hole in the wall next to bed B was observed and the room windows appeared to have tape residue showing an x shape. During an observation on 3/24/2025 at 9:45 a.m. of room [ROOM NUMBER], a hole in the wall was observed underneath the light switch. 50434 4. During an observation on 3/24/2025 at 10:00 a.m. in room [ROOM NUMBER], the walls appeared gouged behind the bed and in need of repair and paint. During an observation on 3/24/2025 at 10:10 a.m. in room [ROOM NUMBER], the walls under the window appeared gouged and in need of repair and paint. During an observation on 3/24/2025 at 10:12 a.m. in room [ROOM NUMBER], a white, unpainted square patch was observed on the wall behind the bed. During an interview on 3/27/2025 at 11:36 a.m., the Nursing Home Administrator (NHA) and Maintenance Director stated they were in the process of ordering melamine or vinyl to put behind the beds to keep the beds from rubbing on the walls and causing the holes. They stated the concerns related to the ceilings in the rooms were likely caused by the hurricane curtains and they had not seen them before today. They stated the holes behind the doors were caused by the door handles and needed to be fixed. The NHA stated he has been at the facility since September and has been working on repairing the rooms. Review of the facility's policy titled Quality of Life - Homelike Environment revised in May 2017 revealed: Policy Statement: Residents are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible. Policy Interpretation and implementation: . (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The facility staff and management shall maximize to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. Review of the facility's policy titled Maintenance Service revised in December 2009 revealed: Policy Statement: Maintenance service shall be provided to all areas of the building, grounds, and equipment. Policy Interpretation and Implementation: 1. The maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include, but are not limited to: a. Maintaining the building and compliance with current federal, state, and local laws, regulations and guidelines. b. Maintaining the building and good repair and free from hazards.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46498 Based on record review and staff interviews, the facility failed to complete the Preadmission Screening and Resident Review (PASARR) Level II upon a new qualifying mental health diagnosis for one resident (Resident #79) of ten residents sampled for PASARR. Findings included: Review of Resident # 79's Admission Record showed he was admitted to the facility on [DATE] with diagnoses to include but not limited to schizoaffective disorder, unspecified, dated 1/13/2025; other specified anxiety disorders, dated 1/10/2023; unspecified dementia, unspecified severity, with agitation, dated 12/12/2022; and Post Traumatic Stress Disorder (PTSD), unspecified, dated 7/28/2022 Review of the Preadmission Screening and Resident Review, signature dated 7/22/2022, revealed in Section 1: PASRR Screen Decision-Making: only Anxiety Disorder was marked as a Mental Illness (MI) or suspected MI. Review of Resident # 79's medical record revealed a new diagnosis of schizoaffective disorder on 1/13/2025 and the resident was not assessed for PASARR Level II. 50434 During an interview on 3/25/2025 at 10:00 a.m. with the Director of Nursing (DON), the DON stated no PASRRs were submitted for a Level II review.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51097 Based on interview and record reviews, the facility failed to ensure Preadmission Screening and Resident Review (PASRR) assessments were accurate and updated to include current diagnoses for three residents (#29, #28, #77) out of 28 sampled residents. Findings included: 1. Review of Resident #29's Admission Record showed Resident #29 was admitted to the facility on [DATE] with diagnoses to include unspecified dementia (added 12/23/20), anxiety (added 4/20/20), and major depressive disorder. Review of the Level I PASRR, dated 7/16/20 showed in Section I: PASRR Screen Decision-Making, A. MI (Mental Illness) or suspected MI (check all that apply), no MI or suspected MI was selected. During an interview on 3/25/25 at 3:28 p.m. with the Director on Nursing (DON), she stated she knew she had a problem because nobody has been doing PASRRs in the facility. She stated she will have to review all the PASRRs. 46498 2. Review of Resident #28 Admission Record revealed she was admitted to the facility on [DATE] with diagnoses to include but not limited to bipolar disorder, current episode depressed, mild or moderate severity, unspecified; depression, unspecified; and panic disorder [Episodic Paroxysmal Anxiety]. Review of Resident #28's Level I PASRR screen, signature dated 3/22/22, in Section I: PASRR Screen Decision-Making, A. MI (Mental Illness) or suspected MI (check all that apply), no MI or suspected MI was selected. 50434 3. Review of Resident #77's Admission Record revealed an admitted [DATE] with diagnosis to include depression, generalized anxiety disorder, and bipolar disorder. A diagnosis of schizoaffective disorder was added on 1/13/25. Review of Resident #28's Level I PASRR screen, signature dated 11/21/24, in Section I: PASRR Screen Decision-Making, A. MI (Mental Illness) or suspected MI (check all that apply), no MI or suspected MI was selected. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled PASARR Re-Evaluation/Determination and Subsequent Review dated 1/29/20 revealed: Policy: Residents should be reevaluated when an individual's mental or physical condition has changed in a manner that effects their need for nursing facility level of care, specialized services, or recommended services of lesser intensity.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 51097 Based on observations, interviews, and record review, the facility failed to ensure the medication error rate was less than 5.00%. Thirty-six medication administration opportunities were observed, and three errors were identified for three residents (#90, #27, and #38) out of four residents observed. These errors constituted a 8.33% medication error rate. Findings included: 1. Review of Resident #90's active orders revealed the following order: Lisinopril Tablet 5 milligrams (mg). Give 1 tablet by mouth one time a day for hypertension. On 3/26/25 at 8:39 a.m., an observation was made of Staff A, Registered Nurse (RN) during medication administration for Resident #90. Staff A, RN did not administer Lisinopril Tablet 5 mg during the observation. The staff member stated he was holding the medication due to a low blood pressure. Review of Resident #90's March 2025 Medication Administration Record (MAR) revealed the following order: - Lisinopril Tablet 5 mg. Give 1 tablet by mouth one time a day for hypertension. The chart code on the MAR was documented as 4 for the dose scheduled to be administered on 3/26/25. Further review of the MAR revealed the definition of chart code 4 = Vitals Outside of Parameters for Administration. Upon review of Resident #90's electronic health record, vital signs were not observed nor able to be located related to the medication administration. 2. On 3/26/25 at 8:52 a.m. an observation was made of Staff B, Licensed Practical Nurse, (LPN) during medication administration for Resident #27. Staff B, LPN dispensed the following medication for Resident #27: - Lidoderm External Patch 5% (Lidocaine). Staff B, LPN labeled the patch with the date 3/26 and her initials. The staff member donned gloves and applied the patch to Resident #27's left upper arm. Review of Resident #27's active orders revealed the following order: - Lidoderm External Patch 5% (Lidocaine). Apply to right shoulder topically one time a day for pain. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of Resident #38's active orders revealed the following order: - Arthritis Pain Reliever External Gel 1% (Diclofenac sodium (topical)) apply to Hands topically two times a day for Dx [diagnosis]: Arthritis. On 3/26/25 at 9:49 a.m. an observation was made of Staff C, RN during medication administration for Resident #38. Staff C, RN did not administer Arthritis Pain Reliever External Gel 1% during the observation. During the observation, Resident #38 stated her hands were hurting her badly. Staff C, RN looked for the Arthritis Pain relieving medication but could not find it. He ordered it from the pharmacy. Staff C, RN stated he does not need to notify the doctor of the missed dose and the resident will just have to wait until tomorrow. On 3/27/25 at 10:55 a.m. an interview with the Director of Nursing (DON) was conducted. The DON stated if a medication is held for vital signs outside of parameters, there should be parameters in the order to hold the medication. She went on to state the doctor should be contacted if a medication is held. A review of the policy titled Administering Medications, with a revision date of April 2019, revealed the following: Policy Statement: Medications are administered in a safe and timely manner, and as prescribed. Policy interpretation and Implementation: . 8. The individual administering medication checks the label to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52156 Based on observations, record review, and interviews, the facility failed to provide food to accommodate preferences for two residents (#39 and #66) out of twenty-two residents sampled for food. Findings included: 1. An observation on 3/24/2025 at 12:40 p.m. revealed Resident #39 sitting up at the bedside for mealtime. She stated she was not supposed to have red meat per her cardiologist and sometimes she felt like she still got it anyway. An observation on her lunch tray revealed a slice of beef covered in sauce. Her meal ticket showed she was supposed to have a Bacon, Lettuce, & Tomato (BLT) sandwich as her entree. She stated she wasn't ever sure what she was being given until she took a bite of it because she had deteriorating vision and could not see what was on her plate. She stated she doesn't ever order anything and they just give her whatever they have that day. She stated most of the time when she realized they gave her something she wasn't supposed to eat, she would just leave it and eat everything else, but she worries she's not getting the protein she needs. An interview was conducted on 3/24/2025 at 12:50 p.m. with Staff D, Certified Nursing Assistant (CNA). Staff D, CNA confirmed the meal ticket showed BLT but the resident had a beef with sauce entree. She stated she does not lift the lids off of the plates for certain residents if they're independent and do not need assistance. Staff D, CNA stated she was not aware of the wrong food item provided to Resident #39 and, that's on the kitchen because they are supposed to be making sure they matched up what the residents pick with what they are giving them. I know those two ladies in there don't like to have their food touched by anyone, so I just deliver their trays and don't open them or anything. An observation and interview were conducted on 3/26/2025 at 12:55 p.m., which revealed Resident #39 sitting up in bed eating her lunch. The resident's meal ticket showed the resident was to have No fish/seafood, No Red Meat, No Pork. The observation revealed her entree was the pork loin entree option. The resident stated she wasn't sure the reason she wasn't supposed to have pork, but she wouldn't eat it. A record review revealed Resident#39 was admitted to the facility on [DATE] with diagnoses to include unspecified severe protein-calorie malnutrition and unspecified macular degeneration. A review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a BIMS (Brief interview for Mental Status) score of 13, indicating intact mental cognition. 2. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and interview was conducted on 3/26/2025 at 1:10 p.m. with Resident #66, which revealed the resident laying in her bed during mealtime. She stated she regularly received food she was not supposed to be having. She stated she regularly received eggs for breakfast when her ticket specifically showed no eggs. Resident #66's meal ticket on date 3/26/2025 showed she was to have a ground hot dog, however, her meal tray had ground pork as her main entree. A record review revealed Resident #66 was admitted to the facility on [DATE] with diagnoses to include hyperglycemia. A review of Resident #66's annual MDS dated [DATE] revealed Resident #66 to have a BIMS score of 15, indicating intact mental cognition. An interview was conducted on 3/26/2025 at 1:25 p.m. with the Food Services Director (FSD). He explained the process of making sure meals matched the meal tickets. The FSD observed the two days of Resident #39 having lunches served to her that did not match her ticket, and also had the main protein being two of the types of meat she was not supposed to get. He reviewed the meal ticket for Resident #66, who had a lunch entree that also did not match her ticket. The FSD confirmed it was an issue, and staff was not checking the tickets like they should have been. An interview was conducted on 3/27/2025 at 10:26 a.m. with the Staff E, Unit Manager (UM). UM explained the expectation for facility staff was to check meal tickets before they served meals to the residents. Staff E, UM confirmed Resident #39 and #66 received the wrong food for their lunch. Review of a facility policy titled Resident Food Preferences, revised July 2017, showed: Policy Statement: Individual food preferences will be assessed upon admission and communicated to the interdisciplinary team. Modifications to diet will only be ordered with the resident's or representative's consent. 1. Upon the resident's admission (or within Seventy-two (72) hours after his/her admission) the Dietician or staff will identify a resident's food preferences. 2. When possible, the staff will interview the resident directly to determine current food preferences based on history and life patterns related to food and mealtimes. 3. Nursing staff will document the resident's food and eating preferences in the care plan. 4. The dietician and nursing staff, assigned by the Physician, will identify any nutritional issues and dietary recommendations that night be un the conflict with the resident's food preferences. 5. The Dietician will discuss with the resident or representative the rationale of any prescribed therapeutic diet. The Physician and Dietician will communicate the risks and benefits of specialized therapeutic vs liberalized diets. 6. Therapeutic diets will be ordered only after the resident/representative agrees with and consents to such a diet. 7. The resident has the right to not comply with therapeutic diets. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8. If the resident refuses or is unhappy with his or her diet, the staff will create a care plan that the resident is satisfied with. 9. Documenting that a resident is refusing meals due to non-compliance with diet orders is not appropriate. 10. The Food Services Department will offer a variety of foods at each scheduled meal, as well as access to nourishing snacks throughout the day and night. 11. The facility's Quality Assessment and Performance Improvement (QAPI) Committee will periodically review for issue related to food preferences and meals to try to identify more widespread concerns about meal offerings, food preparation, etc. Photographic Evidence Obtained

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20536 Based on observations, record reviews, and interviews, the facility failed to 1. Implement an effective infection control program related to the use of Personal Protective Equipment (PPE) in one resident (#162) room of four transmission-based precaution rooms; 2. Failed to store or dispose an indwelling catheter bag when not used for one resident (#78) of six sampled residents who utilized catheters; and 3. Failed to ensure staff completed appropriate hand hygiene during one of three meal observations, (3/24/2025) and during care for one resident (#38) of 42 sampled residents, and 4. Failed to sanitize shared resident equipment after use for one resident (#38) of 42 sampled residents. Findings included: 1. On 3/25/2025 at 7:40 a.m., Staff I, Licensed Practical Nurse (LPN) was observed in the hallway just outside Resident #162's room Staff I, LPN had her medication cart positioned in between the entry way of the room and the hallway. Staff I, LPN was observed standing inside the entry point of the room with her cart in the hallway. After she was finished preparing and pouring medications for Resident #162, she was observed to don clear plastic gloves. At 7:43 a.m. Staff I, LPN picked up the cup of medications off her medication cart and walked to Resident #162, who was seated upright in bed. From the hallway, Staff I, LPN could be observed passing the resident the cup of medications and touched the resident's hands and arms. Staff I, LPN was observed not wearing any other Personal Protective Equipment (PPE) such as a gown and face mask while in the room with Resident #162. Further observations revealed a PPE caddie hanging on the front of the resident's room door, which was stocked with PPE to include gowns, plastic gloves, and face masks. The left wall at the room door entrance had a plastic sign that read; STOP! CONTACT PRECAUTIONS EVERYONE MUST: 1. Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: 1. Put on gloves before room entry, and discard gloves before room exit; 2. Put on gown before room entry, and discard gown before room exit; 3. Do not wear the same gown and gloves for the care of more than one person; 4. Use dedicated or disposable equipment, and clean and disinfect reusable equipment before use on another person. (Photographic Evidence Obtained) Also, observed from the hallway at 7:47 a.m., Staff I, LPN, after completing her medication pass with Resident #162, was observed walking over to the room door and removing her gloves. The staff member proceeded to walk to her medication cart and began to start preparing mediations for another resident. Staff I, LPN, prior to entering Resident #162's room, did not wash her hands prior to donning plastic gloves, did not don a gown, and did not wash her hands after she touched Resident #162's hands and arms. Staff I, LPN also did not wash her hands prior to starting another medication preparation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 7:48 a.m. Staff I, LPN was interviewed related to the infection precautions in the room. Staff I, LPN confirmed the room was on contact precautions. She revealed she should be wearing gloves and a mask and she forgot to don a mask when she entered the room. Staff I, LPN looked at the contact isolation sign on the outside room door wall and confirmed she should have, in conjunction with the gloves she wore, donned a gown. Staff I, LPN stated, I just forgot to wear a face mask and gown before going in the room and I know better. She was not sure about wearing a face mask but stated she should have worn one anyway. Staff I, LPN revealed she was trained and inserviced on the difference between contact isolation rooms and enhanced isolation rooms. Staff I, LPN also confirmed it's only rooms labeled Enhanced infection precautions where they do not need to gown up, unless they are doing physical care with the resident. During the previous day on 3/24/2025 at approximately 10:45 a.m., an interview with Staff E, LPN Unit Manager (UM) confirmed Resident #162 was on contact isolation precautions and upon entering the room, staff and visitors must follow the PPE signage and wash their hands prior to entering the room, and don plastic gloves and a gown. She confirmed Resident #162 was being treated for an infection which required contact isolation infection precautions. On 3/27/2025 at 9:00 a.m., Staff J, LPN, who was at a medication cart near resident room [ROOM NUMBER], was interviewed with relation to infection control and contact isolation precautions. Staff J, LPN revealed they have had rooms on contact isolation precautions to include Resident #162. She revealed the resident had signage on the door indicating the room was on contact precautions. Staff J, LPN confirmed when entering the room, staff should first wash their hands, then don plastic gloves and a gown. She further revealed when completed with care or service, staff should doff the gown and gloves while still in the room and wash hands prior to leaving. Staff J, LPN confirmed she and all other staff receive frequent infection control training from the Infection Preventionist and the Director of Nursing. Staff J, LPN also confirmed, as a nurse, she is to monitor other staff who need to go in contact isolation rooms and ensure they are following the proper PPE requirement. Review of Resident #162's medical record revealed she was admitted on [DATE]. Review of the diagnosis sheet revealed diagnoses to include pneumonia, staph aureus, and need for personal care. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE], revealed the resident had Active Diagnoses of Multidrug Resistant Organism, Pneumonia, and Septicemia. Review of the resident's March 2025 physician's orders revealed the following: A. Initiate Contact Precautions: MRSA (Methicillin-resistant Staphylococcus aureus) Bacteremia every shift Infection Control until 3/26/2025 (Start date 3/18/2025 and end date 3/26/2025). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105616	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER: Carrington Place of St Pete		STREET ADDRESS, CITY, STATE, ZIP CODE: 10501 Roosevelt Blvd N Saint Petersburg, FL 33716	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/27/2025 at 10:20 a.m., Staff E, LPN and Unit Manager (UM) was interviewed and she confirmed Resident #162 was on contact isolation precautions 3/25/2025. Staff E, LPN UM revealed she, along with the Infection Preventionist and the Director of Nursing, provide staff education related to infection control and prevention. She revealed she monitors staff to ensure they follow infection prevention and PPE requirements when it comes to Special Contact isolation precautions, contact isolation precautions, and enhanced barrier precautions. She revealed if staff don't follow the PPE requirements, she will provide immediate education. Staff E, LPN UM confirmed when Resident #162 was on contact isolation precautions, there was a sign on the door that indicated contact isolation precautions and listed the required PPE to wear to include; wash hands prior to entering the room, don gloves and gown prior to entering room, doff PPE, and wash hands prior to leaving the room. Staff E, LPN UM was made aware that Staff I, LPN forgot to wear a gown prior to entering the room for medication pass on 3/25/2025 and stated that should not have happened. Staff E, LPN UM revealed she was confident all staff know the difference of what types of contact isolation precautions and what PPE to wear in those rooms. Staff E, LPN UM also revealed she, the supplies person, and other staff as needed, will ensure the PPE caddy is stocked with the required PPE for each room on contact precautions. 2. On 3/24/2025 at 10:20 a.m., 11:30 a.m., and 12:50 p.m., Resident #78's room was observed seated upright in his bed and with the covers pulled up to his waist, or seated in his wheelchair, while dressed for the day. The room had a faint urine odor, but it could not be determined where the odor was coming from. There were no observations of urinals or use of a catheter. Resident #78 was interviewed and he revealed he used an indwelling catheter at night when he is in bed, but was not observed utilizing one at the time. The bathroom was observed and once entered, the room had a stronger odor of urine. Further observations revealed a blue catheter bag and its tubing were draped and hanging off a metal hand bar directly above the toilet tank. The catheter bag and tubing were hanging off the bar in between the toilet and the sink counter. The catheter bag appeared to have been used previously and still had some yellow liquid in some of the tubing. It was noted Resident #78 had a roommate who shared a bathroom with him. (Photographic Evidence Obtained) During observations on 3/25/2025 at 8:30 a.m., 3/26/2025 at 8:00 a.m., 10:51 a.m., and 2:14 p.m., and on 3/27/2025 at 8:15 a.m.; Resident #78's bathroom was observed each time with the catheter bag and tubing hanging down from the wall metal hand rail, located between the toilet tank and the sink counter. The bathroom had faint urine odor. There were observations during several of the listed dates and times where Resident #78's roommate used the bathroom on his own. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/27/2025 at 10:20 a.m., an interview was conducted with Staff E, LPN UM. She revealed Resident #78 was ordered and utilized an indwelling catheter and all care with it and maintenance of the bag and tubing are completed by nurses. She confirmed Resident #78 did not do catheter care and catheter maintenance on his own. Staff E, LPN UM revealed the resident is supposed to have it on at all times to include bed and when out from bed in wheelchair. She was able to go to Resident #78's room and bathroom and found the catheter bag and tubing was hanging on the wall between the toilet tank and sink counter. She confirmed the catheter bag and tubing should never be hung in the bathroom and she was not sure why that happened, who put it there, and was not sure why there were multiple days of this observed. Staff E, LPN UM could not be certain if the catheter bag and tubing were cleaned and sanitized and the resident should not be doing that on his own. Staff E, LPN UM stated storing the catheter bag and tubing freely on the wall can cause risk for infections. She confirmed Resident #78's roommate uses the bathroom on his own. 3. On 3/24/2025 at 11:45 a.m., the first floor main dining room was observed during the lunch meal service. There were seven residents seated at various tables and with three staff members assisting with lunch meal tray service and set up. At 11:50 a.m. the Admissions Director (AD) was observed walking from a table near the back corner of the room and to the tray cart, which was positioned near the sink counter and doors leading to the kitchen. With her bare hands, she took a tray of food from the cart and brought it over to a resident. She lifted off the lid with her bare hand and placed the lid on the table. She touched the resident's arm and hand as a gesture, picked up a knife and fork and started to cut food items into smaller pieces. The AD gave the fork to the resident and touched her arm and shoulder with her bare hands. The AD picked up an empty tray and lid with her bare hands and brought it over to another cart near the meal tray cart. The AD picked out another meal cart with her bare hands and then walked it over to another resident, where she set up the meal using her bare hands, and touched the resident's fork and knife. After she set up the meal for the resident she continued back to the meal tray cart, removed another meal tray, and brought it to another resident for meal service. The AD never washed or sanitized her hands between, and after resident contact, and did not wash and sanitize her hands after receiving a new meal tray for three residents. The AD was interviewed at 12:04 p.m. She explained she should be sanitizing her hands after each tray pass, after any resident contact, and after touching any contaminated surfaces. She did not remember if she sanitized her hands between the three residents she passed and set up meal trays for. On 3/27/2025 at 2:00 p.m., the Director of Nursing (DON) provided the Isolation - Categories of Transmission-Based Precautions policy and procedure with a revised date of October 2018, for review. The policy revealed the following: Policy Statement: Transmission-Based Precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents. Policy Interpretation and Implementation: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Standard precautions are used when caring for residents at all times regardless of their suspected or confirmed infection status. 2. Transmission-based precautions are additional measures that protect staff, visitors and other residents from becoming infected. These measures are determined by the specific pathogen and how it is spread from person to person. The three types of transmission-based precautions are contact, droplet and airborne. 3. The Centers for Disease Control and Prevention (CDC) maintains a list of diseases, modes of transmission and recommended precautions. 4. The facility makes every effort to use the least restrictive approach to managing individuals with potentially communicable infections. Transmission-based precautions are used only when the spread of infection cannot be reasonably prevented by less restrictive measures. 5. When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door and on the front of the chart so that personnel and visitors are aware of the need for and the type of precaution. a. The signage informs the staff of the type of CDC precaution(s), instructions for use of PPE, and/or instructions to see a nurse before entering the room. b. Signs and notifications comply with the resident's right to confidentiality or privacy. . Contact Precautions: 1. Contact Precautions may be implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. 2. The decision on whether contact precautions are necessary will be evaluated on a case by case basis. 3. The individual on contact precautions will be placed in a private room if possible. If a private room is not available, the Infection Preventionist will assess various risks associated with other resident placement options (e.g., cohorting, placing with a low risk roommate). 4. Staff and visitors will wear gloves (clean, non-sterile) when entering the room. a. While caring for a resident, staff will change gloves after having contact with infective material (for example, fecal material and wound drainage). b. Gloves will be removed and hand hygiene performed before leaving the room. c. Staff will avoid touching potentially contaminated environmental surfaces or items in the resident's room after gloves are removed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Staff and visitors will wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed. On 3/27/2025 at 2:00 p.m. the DON provided the Isolation - Initiating Transmission-Based Precautions policy and procedure, revised October 2018, for review. The policy revealed the following: Policy Statement: Transmission-Based Precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents. Policy Interpretation and Implementation: . 3. When Transmission-Based Precautions are implemented, the Infection Preventionist (or designee: a. Clearly identifies the type of precaution, the anticipated duration, and the personal protective equipment (PPE) that must be used; . c. Provides and/or oversees the education of the resident, representative and/or visitors regarding the precautions and use of PPE; d. Determines the appropriate notification on the room entrance door and on the front of the resident's chart so that personnel and visitors are aware of the need for and type of precautions. 1. The signage informs the staff of the type of CDC precaution(s), instructions for use of PPE, and/or instructions to see a nurse before entering the room. On 3/27/2025 at 2:00 p.m. the DON provided the Handwashing/Hand Hygiene policy and procedure, revised August 2015, for review. The policy revealed the following: Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections. The Policy Interpretation and Implementation: 1. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non- antimicrobial) and water for the following situations: . b. Before and after direct contact with residents; . i. After contact with a resident's intact skin; . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	m. After removing gloves; n. Before and after entering isolation precaution settings; . p. Before and after assisting a resident with meals. 51097 4. On 3/26/25 at 9:49 a.m., an observation was made of Staff C, Registered Nurse (RN). Upon entering Resident #38's room, no hand hygiene was performed. Staff C, RN obtained Resident #38's blood pressure using reusable equipment for multiple resident use. Throughout the observation, no had hygiene was performed and the reusable equipment was not observed to be cleaned prior to or after use.